

THE STATE
HEALTH DEPT.

1

RECEIVED
JAN 10 1918
JAN 10 1918
JAN 10 1918

NAME OF DECEASED
AGE

RESIDENCE

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

Signature of Exr.
Notarized down by Notariable

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Notarized down by Notariable

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Notarized down by Notariable

CERTIFICATE OF DEATH

Reg. Dist. No.

10326

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Philosophers' Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James First Alfred Middle Brice Last		4. DATE OF DEATH Month September Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brice		14. MOTHER'S MAIDEN NAME Anna L. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-3753	
17. INFORMANT Lawrence S. Brice, Betterton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1947 , to September 29, 1959 , that I last saw the deceased alive on September 23, 1959 , and that death occurred at 4:45 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) Chestertown, Maryland	
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.		DATE SIGNED 9-29-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Kent Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR OCT 1 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10300

CERTIFICATE OF DEATH

10300

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Burlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Rural)		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDMUND Middle BROWN Last BROWN		4. DATE OF DEATH Month September Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1886
9. AGE (In years and birthday) 72		10. IF UNDER 1 YEAR Months 7 Days 28	11. IF UNDER 24 HRS. Hours 7 Min. 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Pennsylvania Phila.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Annie Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 159-05-8505	
17. INFORMANT Warren Woodring (cousin)		Address Villanova, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Browning 929.8 DUE TO Had been drinking. Was on pier at Worton Creek Marina, near Chestertown, Md. Was missing for about 2 hours. When found, was lying under water, near his boat at about 5:30 PM. Efforts at resuscitation failed Conditions, if any, which gave rise to immediate cause (b) Marina, near Chestertown, Md. Was missing for about 2 hours. When found, was lying under water, near his boat at about 5:30 PM. Efforts at resuscitation failed (c) 2 hours. When found, was lying under water, near his boat at about 5:30 PM. Efforts at resuscitation failed			INTERVAL BETWEEN ONSET AND DEATH short
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) boat at about 5:30 PM. Efforts at resuscitation failed			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See above. Had apparently fallen overboard.	
20c. TIME OF INJURY Month, Day, Year 3:30 p.m. 9/26/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) See above	20f. (City or town) (County) (State) See above Kent Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED 26 September, 1959	
EXAMINER'S NAME (Type) ROBERT W. FARR		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/59	22c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park	
22d. LOCATION (City, town, or county) (State) Cinnaminson Township N. J.		23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells	
ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

10311

Reg. Dist. No.

10327

1. PLACE OF DEATH a. COUNTY KENT. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY KENT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT EARL BROWN		4. DATE OF DEATH Month Day Year SEP 18 1959	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEP 19, 1912
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PHILA. PA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ROBERT EARL BROWN		14. MOTHER'S MAIDEN NAME MARGARET M. DEWITT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 166-16-0590	
17. INFORMANT HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of STOMACH. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9.12 , 19 59 , to 9.18 , 19 59 , that I last saw the deceased alive on 9.18 , 19 59 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN, MD DATE SIGNED 9.19.59			
ACTUAL SIGNATURE C. J. Keefe, M.D.		PHYSICIAN'S NAME (Type) A. T. KEEFE, M.D.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Normal Sep 23, 1959 Holy Cross Cem.		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Heaton Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Calver Nottingham		24a. REC'D BY REGISTRAR DATE SEP 24 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE William E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

CERTIFICATE OF DEATH

Reg. Dist. No.

10335

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Bertha Middle Clark Last Clark		4. DATE OF DEATH Month Sept. Day 5 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Laurence Whaland		14. MOTHER'S MAIDEN NAME Sarah A. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Walter Clark - Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis with Mitral Insufficiency DUE TO Arterio Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 22, 1959 , to Sept 5, 1959 , that I last saw the deceased alive on Sept 5, 1959 , and that death occurred at 12:45 M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE Norbert C. Nitsch M.D.		ADDRESS (Street, city or town, state) Rock Hall, Maryland	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10313

Reg. Dist. No.

10328

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 6 Wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R.D. 3	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Helen Last Cranor		4. DATE OF DEATH Month Sept. Day 15 Year 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/75
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Cross		14. MOTHER'S MAIDEN NAME Margaret Barrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Edward OBrien		Address Chestertown 3, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis + DUE TO arteriosclerotic heart disease (c) advanced age			INTERVAL BETWEEN ONSET AND DEATH 2 hr. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-1- 19 59 , to 9-15- 19 59 , that I last saw the deceased alive on 9-15- 19 59 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Paul Ross		ADDRESS (Street, city or town, state) DATE SIGNED 203 N Queen St	
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS		Chestertown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 17/59	22c. NAME OF CEMETERY OR CREMATORY St Johns Catholic	22d. LOCATION (City, town, or county) (State) Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 5 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Heights			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS College Heights			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Bryan Davis				4. DATE OF DEATH Month Day Year Sept. 21 1959			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27 1889	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard M. Bryan				14. MOTHER'S MAIDEN NAME Carolyn Deputy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William E. Davis		Address Chestertown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple duodenal diverticulosis; hiatus hernia, with hiatus insufficiency						INTERVAL BETWEEN ONSET AND DEATH 10 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown, Md.	(County)	(State)		
21. I certify that I attended the deceased from 10-12 , 19 58 , to Sept. 21 , 19 59 , that I last saw the deceased alive on Sept. 19 , 19 59 , and that death occurred at 7:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 9-21-59							
ACTUAL SIGNATURE A.C. Dick M.D.							
PHYSICIAN'S NAME (Type) A.C. Dick, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 24/59	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams			ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE SEP 25 59	24b. REGISTRAR'S SIGNATURE Arthur H. Williams		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home of daughter		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First George W. Middle Gorsuch Last Sr.		4. DATE OF DEATH Month Sept. Day 28 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1885
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker (Ret.) Fish Hatchery		10b. KIND OF BUSINESS OR INDUSTRY State	
11. BIRTHPLACE (State or foreign country) Baltimore City Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Gorsuch		14. MOTHER'S MAIDEN NAME Emma Woodward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Edw. Robinson		Address Morgnec Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized circulatory collapse 415X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Rheumatic fever			INTERVAL BETWEEN ONSET AND DEATH 8 hours 10 years 62 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage in 1952 - partial paralysis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15 , 19 59 , to 9-28 , 19 59 , that I last saw the deceased alive on 9-27 , 19 59 , and that death occurred at 5:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 9-29-59			
ACTUAL SIGNATURE A. C. Dick		PHYSICIAN'S NAME (Type) A. C. Dick	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/59	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE OCT 1 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF DEATH	
JAN. 20, 1888		JAN. 20, 1900	
AGE		AGE	
12 YEARS		12 YEARS	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
NAME OF DECEASED		NAME OF DECEASED	
GEORGE A. BOHANNON, JR.		GEORGE A. BOHANNON, JR.	
RESIDENCE		RESIDENCE	
BALTIMORE, MD.		BALTIMORE, MD.	
OCCUPATION		OCCUPATION	
CLOCK REPAIRER		CLOCK REPAIRER	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
PERIOD OF ILLNESS		PERIOD OF ILLNESS	
10 DAYS		10 DAYS	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MD.		BALTIMORE, MD.	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
BALTIMORE, MD.		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. A. BOHANNON, JR.		J. A. BOHANNON, JR.	
DATE		DATE	
JAN. 20, 1900		JAN. 20, 1900	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF BIRTH		DATE OF BIRTH	
JAN. 20, 1888		JAN. 20, 1888	
AGE		AGE	
12 YEARS		12 YEARS	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
NAME OF DECEASED		NAME OF DECEASED	
GEORGE A. BOHANNON, JR.		GEORGE A. BOHANNON, JR.	
RESIDENCE		RESIDENCE	
BALTIMORE, MD.		BALTIMORE, MD.	
OCCUPATION		OCCUPATION	
CLOCK REPAIRER		CLOCK REPAIRER	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
PERIOD OF ILLNESS		PERIOD OF ILLNESS	
10 DAYS		10 DAYS	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MD.		BALTIMORE, MD.	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
BALTIMORE, MD.		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. A. BOHANNON, JR.		J. A. BOHANNON, JR.	
DATE		DATE	
JAN. 20, 1900		JAN. 20, 1900	

RECEIVED
JAN 21 1900
BALTIMORE, MD.

10331

CERTIFICATE OF DEATH

10316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Annt Co. Hosp</u>				1d. STREET ADDRESS <u>529 1/2 High St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Dudley</u> Last <u>Jarvis</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>16</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1905</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
3. FATHER'S NAME <u>John T. Jarvis</u>				14. MOTHER'S MAIDEN NAME <u>Alice Morland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Mary Jarvis</u> Address <u>Chestertown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chemical peritonitis due to rupture of stomach</u> DUE TO <u>Carcinoma of stomach</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>48 hours</u> <u>Not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-14</u> , 19 <u>59</u> , to <u>9-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-15</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>				DATE SIGNED <u>9-16-59</u>			
ACTUAL SIGNATURE <u>A. C. Dick</u>				M.D. <u>Chestertown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>				<u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1888</i>		5. PLACE OF BIRTH <i>Sweden</i>	
6. OCCUPATION <i>Farmer</i>		7. MARITAL STATUS <i>Married</i>		8. COLOR OF SKIN <i>White</i>		9. COLOR OF HAIR <i>Brown</i>		10. COLOR OF EYES <i>Blue</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>		13. DATE OF DEATH <i>Dec 10 1933</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
16. SIGNATURE OF REGISTRAR <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	

MAKALAND STATE DEPARTMENT OF HEALTH - BANGOR, 18

MAKALAND STATE DEPARTMENT OF HEALTH - BANGOR, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10317

Reg. Dist. No.

10332

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b <u>less than 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent & Queen Annes General</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Route 1</u> d. STREET ADDRESS <u>17X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Diane</u> Last <u>Lloyd</u>				4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>March 2, 1955</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew L. Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Boyles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Josephine Lloyd, Chestertown, Md, (mother)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Unknown, but probably Natural Causes</u> IMMEDIATE CAUSE (a) <u>795.2</u> DUE TO <u>Had been apparently in good health until about 4:30PM, when she was found lying on the floor in front of the TV set.</u> Conditions, if any, which gave rise to immediate cause (b) <u>She had fallen from a low stool. Was a little stiff, but was</u> (a), stating the underlying cause last. DUE TO <u>conscious and knew members of the family. Was brought to the</u> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hospital emergency room, had what seems to have a seizure on the way and</u> <u>was dead on arrival. Rectal temperature on arrival was 103.4.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20a. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input checked="" type="checkbox"/>.								
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>8 September, 1959</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 11</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON</u>		22d. LOCATION (City, town, or county) (State) <u>CRUMPTON</u> <u>M.D.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				24a. REC'D BY REGISTRAR <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10817

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10802

FOR STATE
HEALTH DEPT



Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: John Doe
AGE: 45 SEX: M RACE: W
DATE OF DEATH: 10/15/1917
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE: [Signature]
DATE: 10/16/1917

Vertical text on the right margin, likely a filing or processing stamp.

10333

CERTIFICATE OF DEATH

Reg. Dist. No.

10318

1. PLACE OF DEATH a. COUNTY Kent County, MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 10 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First James Middle Dunham Last McVean			4. DATE OF DEATH Month 9 Day 1 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-87		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agriculture Agent		10b. KIND OF BUSINESS OR INDUSTRY State Employee	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Alexander McVean			14. MOTHER'S MAIDEN NAME Grace Robertson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-38-8766	INFORMANT Address Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic ileus 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction DUE TO (c) Adhesion and regional ileitis					INTERVAL BETWEEN ONSET AND DEATH 9 days 10 days 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-22 , 1959 , to 9-1 , 1959 that I last saw the deceased alive on 9-1 , 1959 , and that death occurred at 3:30 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) DATE SIGNED Chestertown, Maryland 9-1-59			
PHYSICIAN'S NAME (Type) A.C. Dick					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.	
22d. LOCATION (City, town, or county) (State) Winchester New Hampshire		24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	
23. FUNERAL DIRECTOR'S SIGNATURE G. Willis Wells		ADDRESS Chestertown, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

10333

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Dec 19 1918
New York City
10 days

Philosophy Institute
1000 and Ocean Avenue, Brooklyn

John Alexander
1000 and Ocean Avenue, Brooklyn

John Alexander
1000 and Ocean Avenue, Brooklyn

John Alexander
1000 and Ocean Avenue, Brooklyn

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John Alexander
1000 and Ocean Avenue, Brooklyn

John Alexander
1000 and Ocean Avenue, Brooklyn

10336

CERTIFICATE OF DEATH

10319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ferry Park</u>		d. STREET ADDRESS <u>Ferry Park</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Thomas Rambo</u>		4. DATE OF DEATH Month / Day / Year <u>9 / 16 / 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Bridgeton, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Bacon</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Craig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>162-09-5782</u>	
17. INFORMANT <u>Harry C. Rambo</u>		Address <u>Bryshore Rd, Ferry Park, Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Myocardial Damage</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>MD.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u>		DATE SIGNED <u>9/16/59</u>	
PHYSICIAN'S NAME (Type) <u>William M. Gatewood, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Birmingham Infirmary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>West Chester Chester Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Norman Wiley</u>		ADDRESS <u>2813 N 13th Phila Pa</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10320

Reg. Dist. No.

10337

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Chestertown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 213				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynch			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy Middle Styer Last				4. DATE OF DEATH Sept. 5, 1959 Month 19 Day 19 Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/59 29	
				9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress				10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Patrick				14. MOTHER'S MAIDEN NAME Mary Ellen Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 20-24-4286		17. INFORMANT Address Mother Mary Patrick Craumer Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Injuries to chest 823X DUE TO Automobile accident Conditions, if any, which gave rise to immediate cause (b) Automobile accident (c) Automobile accident DUE TO Automobile accident causing the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - crashed into embankment			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5:45 A.M. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Highway intersection near Chestertown, Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59		22c. NAME OF CEMETERY OR CREMATORY Chestertown Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
						24b. REGISTRAR'S SIGNATURE Robert W. Farr	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10830

1. PLACE OF DEATH RESIDENCE		2. DATE OF DEATH	
3. CITY AND COUNTY		4. DEPARTMENT OF HEALTH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. MEDICAL HISTORY	
13. PRESENT ILLNESS		14. POST-MORTEM EXAMINATION	
15. SIGNATURE OF EXAMINER		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF MINISTER OF THE GOSPEL		20. SIGNATURE OF CLERGYMAN	
21. SIGNATURE OF CHURCH WARDEN		22. SIGNATURE OF BURIAL SOCIETY	
23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
25. SIGNATURE OF HEALTH OFFICER		26. SIGNATURE OF ASSISTANT HEALTH OFFICER	
27. SIGNATURE OF NURSE		28. SIGNATURE OF PHYSICIAN	
29. SIGNATURE OF DENTIST		30. SIGNATURE OF VETERINARIAN	
31. SIGNATURE OF MIDWIFE		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER	
45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER	
47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER	
53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER	
57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER	
59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER	
63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER	
75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER	
83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER	
87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10321

10338

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 213		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lynch d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Earl Styer First Middle Last		4. DATE OF DEATH Sept. 5, 1959 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1926
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Augustus Styer		14. MOTHER'S MAIDEN NAME Charlotte A. McCardell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes If yes, give war or dates of service WWII		16. SOCIAL SECURITY NO. 214-22-1988	
17. INFORMANT Mary Patrick Craumer Address Mother -in-Law Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Injuries to chest due to DUE TO 823 X Sterring wheel impact auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Instantaneous (c) Distantaneous		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Auto accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:45 AM 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Intersection near Chestertown, Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE Orlino & Hand	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P100. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10322

10339

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle J. Last Walbert		4. DATE OF DEATH Month September Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Theodore L. Walbert		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. none	
17. INFORMANT Morris Walbert--Chestertown, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate with metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Chestertown, Md.		(County) (State)	
21. I certify that I attended the deceased from 10-19-58 , 19 58 , to Sept. 16 , 19 59 , that I last saw the deceased alive on Sept. 15 , 19 59 , and that death occurred at 5:00p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Sept. 17, 1959			
ACTUAL SIGNATURE A.C. Dick		M.D. A.C. Dick, M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 19	22c. NAME OF CEMETERY OR CREMATORY Centreville	22d. LOCATION (City, town, or county) (State) Centreville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Colgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10338

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. BIRTH DATE 10/15/1890		6. BIRTH PLACE Baltimore, Md.		7. MARITAL STATUS Married		8. OCCUPATION Teacher		9. CAUSE OF DEATH Heart Disease		10. PLACE OF DEATH Home		11. TIME OF DEATH 10:30 AM		12. SIGNATURE OF REGISTRAR J. H. Smith		13. SIGNATURE OF PHYSICIAN D. J. Smith		14. SIGNATURE OF CLERGYMAN R. J. Smith		15. SIGNATURE OF WITNESSES A. J. Smith, B. J. Smith	
16. PLACE OF BIRTH Baltimore, Md.		17. PLACE OF DEATH Home		18. TIME OF DEATH 10:30 AM		19. CAUSE OF DEATH Heart Disease		20. PLACE OF DEATH Home		21. TIME OF DEATH 10:30 AM		22. SIGNATURE OF REGISTRAR J. H. Smith		23. SIGNATURE OF PHYSICIAN D. J. Smith		24. SIGNATURE OF CLERGYMAN R. J. Smith		25. SIGNATURE OF WITNESSES A. J. Smith, B. J. Smith		26. PLACE OF BIRTH Baltimore, Md.		27. PLACE OF DEATH Home		28. TIME OF DEATH 10:30 AM		29. CAUSE OF DEATH Heart Disease		30. PLACE OF DEATH Home	